

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. It should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked or item 18 shows any injury or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG NO. 26423											
1. DECEASED NAME (TYPE OR PRINT)			FIRST BERNICE	MIDDLE TYLER	LAST AARON	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
3. SEX FEMALE			4. RACE CAU.			5. DATE OF BIRTH MONTH DAY YEAR April 16, 1906			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 81 yrs		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) maryland			7b. CITIZEN OF WHAT COUNTRY? u.s.a.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.		
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) book-keeper			12b. KIND OF BUSINESS OR INDUSTRY seafood		
13a. STATE MARYLAND			13b. COUNTY DORCHESTER			13c. CITY OR TOWN CAMBRIDGE			13e. STREET ADDRESS / ZIP CODE 21613 311 Glenburn Ave.		
14. FATHER'S NAME FIRST HERBERT			MIDDLE HANSEL	LAST TYLER, SR.	15. MOTHER'S MAIDEN NAME FIRST ALBERTHA			MIDDLE	LAST PHILLIPS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-07-7770			17. INFORMANT ADDRESS Lutherville, Md. niece Deborah Kaminski, 625 College Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE STROKE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 46 days.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) this hospital attended the deceased from 1985 to 9-9-1987, that (I) (we) last saw the deceased alive on 9-9-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael A. Moskewicz		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-9-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Moskewicz		22e. ADDRESS 503 BYRN ST CAMBRIDGE MD. 21613									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/11/87		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk. Airey, Cambridge, Dor., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Curran Funeral Home						25. DATE PREPARED BY REGISTRAR 21 SEP 14 1987					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and transmitted to the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy (page 1) from this certificate and file it within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 2642

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
CHARLES NATHAN ARNOLD							SEPT.	1,	1987		M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
MALE		WHITE		Oct. 31 1908			78							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			DORCHESTER				
Balt. Md.		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
HURLOCK		506 Glen Oak Circle (home)					Dock Worker			Transfer & Storage				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Dorchester		Hurlock						P.O. Box 364 506 Glen Oak Circle, 21643				
14. FATHER'S NAME FIRST		ARNOLD		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
JOHN							LAURA			UNKN			HALBERT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			17. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		212-07-1667		Mrs. Kathryn Anna Arnold			Hastings			Same as 13a				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive Pulmonary Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>P. Gregg Rhodes</i>		22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>9/2/87</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			22e. ADDRESS						
P. Gregg Rhodes, M.D.					503 Dutchman's Lane Easton, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY			23f. STATE		
Burial		9-4-1987		Glen Haven Cem.			Glen Burnie, A. A.		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS			308 High St.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
CURRAN FUNERAL HOME		CAMBRIDGE, MD.						SEP 8 1987		<i>Jane Deacon-Randall</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 8 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 9 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 10 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 11 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 12 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 14 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 15 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 16 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 17 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 18 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 19 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 20 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 21 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 22 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 23 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 24 should be detached for use as the burial-transit permit. Then please remove carbon papers.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be retained and informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 2642
1. DECEASED NAME (TYPE OR PRINT) <i>Booze, Lydia</i>		MIDDLE <i>Frost</i>	LAST	2a. DATE OF DEATH MONTH <i>JULY</i> DAY <i>22</i> YEAR <i>87</i>	2b. HOUR 11:25 A.M.
3. SEX female		4. RACE white	5. DATE OF BIRTH MONTH <i>JULY</i> DAY <i>23</i> YEAR <i>1903</i>	6. AGE (IN YEARS LAST BIRTHDAY) 84	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> IF UNDER 24 HRS HOURS <i>0</i> MIN. <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker
13a. STATE Md.		13b. COUNTY Dor.	13c. CITY OR TOWN Church Creek	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 21622
14. FATHER'S NAME FIRST William		MIDDLE Andrews	LAST Sally	15. MOTHER'S MAIDEN NAME Shorter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-50-8815	17. INFORMANT Dwight C. Booze	ADDRESS Box 7	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vertebral artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Constrictive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atrial fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b <i>Dilated mitral.</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> MONTH <i>JULY</i> DAY <i>22</i> YEAR <i>87</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>922</i>	21f. LOCATION STREET <i>302 Collins Harlock</i>	CITY OR TOWN <i>MD 21643</i>	COUNTY <i>Hanover</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>1987</i> 1987, 19_____, to <i>9-22</i> 1987 that (we) last saw the deceased alive on <i>9-22</i> 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Michael J. Fadden MD</i>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>9-22-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael J. Fadden MD</i>		22e. ADDRESS <i>302 Collins Harlock</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/24/87	23c. NAME OF CEMETERY OR CREMATORIAL DOR. MEM. PARK	23d. LOCATION CITY OR TOWN <i>CAMBRIDGE</i>	COUNTY <i>DOR.</i>
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.	25a. DATE REC'D. BY REGISTRAR <i>SEP 30 1987</i> 25b. REGISTRAR'S SIGNATURE <i>Jeanne Dawson-Landale</i>		
DHMH - 16 60M 7/84 (VRA 15, 4)					

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17-87  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

26420

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Julia E Briggs						8 26 87				11 28 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F.		BLACK		MONTH	DAY	YEAR	69	MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE, OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.								Porchester	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. KIND OF BUSINESS OR INDUSTRY							
Cambridge		DORCHESTER GENERAL HOSP.		Board of Ed.							
13a. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		ZIP CODE			
Md.		Dorchester Harlock		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt # 1 Box 1092		1643			
14. FATHER'S NAME		15. MOTHER'S M AIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		ADDRESS			
Andrew		Lullie Mae Wing		No		Robert Q Briggs		At 1 Bay St 109			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Myocardial infarction		DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrest & resuscitation		DUE TO, OR AS A CONSEQUENCE OF (c) Persistent Vegetative state		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								3			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
HBP, AODM											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from 1985, 19, to 5 27, 19 87, the (we) last saw the deceased alive on 8 27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.						COUNTY					
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Michael J Falolen MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Burial		8-31-87 Solomons		302 Collins Harlock MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN					
Burial		8-31-87		Solomons		Williamsburg Dr. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Bennie Smith P.O. Box 928 Md.				SEP 16 1987							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attendant physician it should be filed in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 2 and file within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition. If the medical examiner must be notified, attach a copy of this certificate to the report of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, attach a copy of this certificate to the report of death.

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1871 932

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death be reported by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**4**  
06753 | OCT-2-87  
executed within 24 hours after death. Page 4 may be filed within 24 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										26427		
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
Cornelia				Cephas	Cephas	Month	Day	Year	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	MIN.	
3. SEX Female			4. RACE Negro	5. DATE OF BIRTH 3/30/1899			6. AGE (In years lost birthday) 88 YRS.					
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dor. Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Dor	13c. CITY OR TOWN Camb			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 631 Washington St. 21613		
14. FATHER'S NAME First ?			Middle	Last	15. MOTHER'S MAIDEN NAME First Cephas Louise			Middle	Last - Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 211-12-5426			17. INFORMANT (Son) Emerson Cephas			Address 631 Wash. St. 21613			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>CHF HBP</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State	
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on <i>6/30/87</i> 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>9/30/87</i>		
22b. SIGNATURE <i>Hubert L. Berry</i>		22d. PHYSICIAN'S NAME (Type) <i>Hubert L. Berry</i>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE 9/24/87		23c. NAME OF CEMETERY OR CREMATORIAL Bethel AME Cem.			23d. LOCATION (City or Town) Camb.		(County)	(State)		
24. FUNERAL DIRECTOR L.H. Boa rdley F/H Camb., Md. 21613		ADDRESS			25a. REC'D. BY REGISTRAR SEP 28 1987			25b. REGISTRAR'S SIGNATURE <i>J. J. JONES</i>				

000-11182100-501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If Item 21 is marked "Yes", the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 26429			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Doris			Cornish			9 11 87			8:20 A	
SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			Negro			02 9 88							
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.				
10 CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Factory				
13a. STATE Maryland			13b. COUNTY Dorchester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 806 Maces Lane 21613				
14. FATHER'S NAME First: Luther			Middle: Ward			15. MOTHER'S MAIDEN NAME First: Mary			Middle: Elizabeth			Last: Bryan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-12-6726			17. INFORMANT Fred W. Cornish			ADDRESS 21613 808 Maces Land				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Death APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> Years { DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis Cardiovascular Disease</u> Years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
		22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 87</u> , to <u>9 11 87</u> , that (I) (we) last saw the deceased alive on <u>Aug 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
		22b. SIGNATURE <u>Bryant</u>		22c. DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 21613			
		22e. PHYSICIAN'S NAME (TYPE OR PRINT) H.C. AYLIFFE		22f. ADDRESS 407 BYRN ST. (CAMBRIDGE)									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/16/87		23c. NAME OF CEMETERY OR CREMATORIAL Hughes Mission				23d. LOCATION CITY OR TOWN Cambridge		COUNTY Dorchester	STATE MD		
24. FUNERAL DIRECTOR NAME Boardley Funeral Home		ADDRESS 812 Hubbard St.		25a. DATE REC'D. BY REGISTRAR 21613 SEP 16 1987				25b. REGISTRAR'S SIGNATURE <u>Jeanne Anderson</u>					

1942 92 105000



1942 92 105000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove and send papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked with an X, show any injury, or other traumatic event, the medical examiner must be notified.

15-87  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26429  
4

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			EDNA	WILSIE	DERR	9-10-87				10 <sup>57</sup> M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		
Female			White			July 20, 1899			88 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.		
Maryland			US								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			Dorchester General Hospital			Homemaker					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Dorchester			Cambridge			13e. STREET ADDRESS / ZIP CODE 113 Willis St. 21613		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Louise MIDDLE D. LAST Willson		
Winfield Merritt Brohawn											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
No			217-10-8028			Lillian B. Hurley Item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute massive Anterolateral myocardial infarction 22 hrs</i> DO TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DO TO, OR AS A CONSEQUENCE OF (c) <i>Acute and chronic diverticulitis of sigmoid colon</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Acute and chronic diverticulitis of sigmoid colon</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED FURTHER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/10 87</i> , to <i>9/10 87</i> , that (I) (we) last saw the deceased alive on <i>9/10 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>Donald R. McWilliams M.D.</i>			22c. DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9-10-87</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD R. McWILLIAMS, M.D.</i>			22f. ADDRESS <i>308 GAY STREET CAMBRIDGE, MD. 21613</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 6/12/87			23c. NAME OF CEMETERY OR CREMATORIAL Dor. Mem Park			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME CAMBRIDGE, MD.</i>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>SEP 14 1987 Julia Davidson-Lindner</i>								

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 4A. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2645L		
1. DECEASED NAME (TYPE OR PRINT)				FIRST Rhett	MIDDLE	LAST Ennels	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH 9	DAY 8	YEAR 1987	2b. HOUR M
3. SEX male	4. RACE B 2	5. DATE OF BIRTH MONTH 3	DAY 28	YEAR 41	6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD	MONTH 9	DAY 11	YEAR 1987	2d. HOUR 1030A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co.					MD.		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.	13b. COUNTY Dor.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 600 Greenwood Ave. Apt. 301		21613							
14. FATHER'S NAME FIRST Ernest		MIDDLE O.	LAST Ennels	15. MOTHER'S MAIDEN NAME FIRST Gladys		MIDDLE	LAST Wilson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 216-38-7581		17. INFORMANT Donna Ennels		ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant hypertension												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> <div style="border-left: 1px solid black; padding-left: 10px;">         (b) _____          DUE TO, OR AS A CONSEQUENCE OF           (c) _____          DUE TO, OR AS A CONSEQUENCE OF       </div>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Peter W. Rieckert</i>		TITLE (SPECIFY) M.D.		Dep.		MEDICAL EXAMINER		DATE SIGNED 9-15-87						
EXAMINER'S NAME (TYPE OR PRINT)		Peter W. Rieckert, M. D. Beach Haven, East New Market, Md.												
23a. BURIAL, CREMATION, REMOVAL (SIC) CRY		23b. DATE 9-14-87		23c. NAME OF CEMETERY OR CREMATORIAL V.A. Cemetery		23d. LOCATION CITY OR TOWN Hurlock		COUNTY Dor.		STATE Md.				
24. FUNERAL DIRECTOR NAME Stewart Funeral Home		ADDRESS 510 Washington St.		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE <i>Julia S. Ladd</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed once.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

2643

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<b>JOHN JOHNIE FORTUNE</b>						<b>9-21-87</b>				<b>1:34 P.M.</b>	
3 SEX	4 RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.		
<b>MALE</b>	<b>BLACK</b>	<b>3 20 18</b>	<b>65</b>	<b>69</b>							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH				
<b>Nassau, Brit. Isle</b>							<b>DORCHESTER</b>				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
<b>Cambridge</b>	<b>Eastern Shore Hospital Center</b>					<b>Construction Laborer</b>					
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	13e STREET ADDRESS				
<b>MD</b>	<b>DORCH.</b>	<b>CAMBRIDGE</b>					<b>21673 Cambridge House Nursing Home</b>				
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
<b>Mac</b>			<b>FORTUNE</b>	<b>Queen</b>				<b>Fortune</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT					ADDRESS				
<b>No</b>	<b>070-14-2322</b>	<b>E.S.H.C.</b>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Emboli, Bilateral</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic Cardiovascular Disease, Cerebral Infarcts</b>											
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
<b>None</b>	<b>-</b>					YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NA</b>									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET					CITY OR TOWN	COUNTY	STATE		
22a I certify that <b>(he/his)</b> attended the deceased from <b>12 NOV 1986</b> to <b>21 SEP 1987</b> , that <b>(we/he)</b> lost saw the deceased alive on <b>21 SEP 1987</b> , and that in <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(did)</b> <b>(did not)</b> view the body after death.											
22b SIGNATURE <b>Paul A. Staggs, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
22c DATE SIGNED <b>22 Sep 87</b>											
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL A. STAGGS, M.D.</b> ADDRESS <b>Eastern Shore Hospital Center</b>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORIAL <b>Waugh Cemetery</b>					23d LOCATION CITY OR TOWN <b>Cambridge, Dor. Md.</b>	COUNTY	STATE	
24 FUNERAL DIRECTOR NAME		ADDRESS	25a DATE REC'D. BY REGISTRAR					25b REGISTRAR'S SIGNATURE <b>OCT 1 1987</b>			
<b>Stewart Funeral Home Cambridge MD</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 26452	
DECEDENT NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR	
Emily Hancock Grieco						96	07	2:40 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH June DAY 20, 1909 YEAR		78		MONTHS YRS		MONTHS DAYS HOURS MIN.	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b>					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>					
13a. STATE <b>MD</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>407 Noble Street/21643</b>			
14. FATHER'S NAME <b>John</b>		FIRST MIDDLE LAST <b>Gilbert Cuthbertson</b>		15. MOTHER'S MAIDEN NAME <b>Ellen Rolle</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT <b>Rt. 1, Box 270 Margaret Stiles, Hurlock, MD 21643</b>							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Obstructive Pulmonary Disease</i> (c) <i>Cigarettes</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Congestive Heart Failure</i>											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/20</u> 19 <u>87</u> , to <u>Aug 19 87</u> , that (I) (we) last saw the deceased <u>alive</u> , (I) (we) did <u>not</u> view the body after death.											
22b. SIGNATURE <i>H.E. Ayotte</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>9/8/87</u>					
22e. ADDRESS <i>408 Ryan St. (unnumbered no)</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-8-87</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Unity Washington Cem</b>		23d. LOCATION CITY OR TOWN <b>Hurlock</b>		COUNTY <b>Dorchester</b>		STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <i>Zeller Funeral Home, East New Market, MD</i> ADDRESS <i>SEP 16 1987</i> 25a. DATE REC'D. BY REGISTRAR VRA 15, 4 25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Randall</i>											

0062822 SEP 15 1981

SEP 16 1981

065062 SEP 9 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do it now.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and sign the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, medical certification should be obtained.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2643

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CHARLES			William		HAETLER, Sr.	Sept 2, 1987	2	87		3:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUC		Dec 30, 1917				69 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		US						Dorchester Co.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Dorchester General Hospital						Auto Body Repair Retired			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Taylors Island		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 111		21669	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Conrad				Fred Haetler		Mabel		Marie		Nace	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		17. ADDRESS					
No		213-03-4853		Helen S. Haetler Item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hyp</u> DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>DIABETES, LUNG Ca, OBESITY</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from <u>8/25</u> , 19 <u>87</u> , to <u>9/2</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8/20</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did (did not) view the body after death.											
22b. SIGNATURE <u>HUBERT J. FIORI</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>9/2/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT J. FIORI</u>		22e. ADDRESS <u>503 BYRN ST</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/4/87		23c. NAME OF CEMETERY OR CREMATORIAL Dor Mem Park		23d. LOCATION CITY OR TOWN Cambridge, Dor. Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Sanderson-Lundeen</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Paper 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be left with the funeral director until after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 19 shows any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										26434			
										REG. NO.			
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		JOHN GRAFTON		HUGHES		3. DATE OF DEATH		MONTH	DAY	YEAR	26. HOUR
		JOHN		G		HUGHES		9-14-87				8:40 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
MALE		CAUC		MARCH 14 03		84 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER		10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER	
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 700 SPRINGFIELD AVE., 21613		12b. KIND OF BUSINESS OR INDUSTRY TRANSPORT.			
14. FATHER'S NAME FIRST ELIJAH		MIDDLE F.		LAST HUGHES		15. MOTHER'S MAIDEN NAME FIRST JENNIE		MIDDLE		LAST SPENCER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		16c. INFORMANT MILDRED JONES		17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CVA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) NASCVD		(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Peripheral vascular disease, CHD, COPD, Renal failure, CHF													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Hulbert L. Fiery</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED SEP 17 1987									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hulbert L. Fiery		22e. ADDRESS 308 High St. Cambridge, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-17-87		23c. NAME OF CEMETERY OR CREMATORIAL East New Market C.		23d. LOCATION CITY OR TOWN East New Mkt. Dorc. Md.		23e. COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Curran Funeral Home		ADDRESS 308 High St. Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE <i>John G. Grafton</i>							

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The death certificate be executed within 24 hours after death. Page 4 may be

HOSPITAL OR ATTENDING PHYSICIAN. The

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2643

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	
Virginia Dennis Jones						2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Cauc		MONTH 7	DAY 17	YEAR 96	IF UNDER 1 YEAR 91 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
USA		USA				Dorchester Co., MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CAMBRIDGE		D6H		Homemaker		21613 Ave.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Dorchester		Cambridge		13e. STREET ADDRESS / ZIP CODE 7 Bay Heights	
14. FATHER'S NAME		FIRST Will	MIDDLE	LAST Dennis	15. MOTHER'S MAIDEN NAME		MIDDLE LAST Parrott
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		214-07-9101					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Sepsis - 2° to UTI						3	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) A septicemia						48 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: extreme age, OBS, rheumatoid arthritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (1) this hospital attended the deceased from 9/3/87, 19 87, to 9/3, 19 87, that (1) (we) last saw the deceased alive on 9/3, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
HUBERT L. FIEBY		503 BYRN ST					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/6/87		23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery		23d. LOCATION CITY OR TOWN Cambridge COUNTY Dor. STATE Md.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 10 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Bonadelle	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												26436
											REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
JAMES					LARMORE	SEPT.	25, 1987			10:30 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 YEARS		
MALE		CAU.		MONTH	DAY	YEAR	74	YRS	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.		
DEL.		U.S.A.						DORCHESTER		STONE		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF INDUSTRY						
CAMBRIDGE		PORCHESTER GENERAL HOSPITAL		ENGRAVER		MEMORIAL		21613				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE				
MARYLAND		DORCHESTER		CAMBRIDGE				606 GOLDSBOROUGH AVE.				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
JAMES					LARMORE	SALLY ANN BROWN						
16a WAS DECEASSED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES			WWII		220-03-1611 Mrs. Dorothy Dudly Larmore same as 13e							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LIVER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARCINOMA OF LIVER WEEKS												
DO TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
9/18/87			Carcinoma of Liver				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (We) attended the deceased from 9/10/87 to 9/25/87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.												
22b. SIGNATURE DAVID B. SPECKLE			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/26/87					
22d. PHYSICIAN'S NAME (IF DIFFERENT) DAVID B. SPECKLE M.D.			22e. ADDRESS 260 MARYLAND AVE CAMBRIDGE, MD 21613									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE burial 9/28/87		23c. NAME OF CEMETERY OR CREMATORIAL PORCHESTER MEM. PK.		23d. LOCATION AIREY, CAMBRIDGE, DOR., MD.					
24. FUNERAL DIRECTOR NAME			Curran Funeral Home 21613 308 High St., Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR SEP 30 1987		25b. REGISTRAR'S SIGNATURE Julia Sander-Landress					

W-1-788-885780

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Original

BB-08932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 26457		
1 - STATE REGISTRAR			2a. DATE OF DEATH 9 23 87							MONTH DAY YEAR		
(DECEASED NAME (TYPE OR PRINT))			FIRST JAMES		MIDDLE G		LAST LEWIS		2b. HOUR 10:32 P.M.			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH 8 DAY 6 YEAR 15			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY			
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL			12a. USUAL OCCUPATION SHIFT ENGINEER			12b. KIND OF BUSINESS OR INDUSTRY UTILITY			
13a. STATE MD			13b. COUNTY DORCHESTER			13c. CITY OR TOWN VIENNA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST JOHN MIDDLE HENRY LAST LEWIS						15. MOTHER'S MAIDEN NAME FIRST MARION MIDDLE ELIZABETH LAST FRY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT P. O. BOX 217			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS			
19. MEDICAL CERTIFICATION												
19a. DATE OF OPERATION 9/23/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal aortic aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/23 1987 to 9/23 1987 that (I) we last saw the deceased alive on 9/23 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE DAVID B. SOECKLE			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/23/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. SOECKLE M.D.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-26-87			23c. NAME OF CEMETERY OR CREMATORIAL ST. PAUL'S CEMETERY			23d. LOCATION CITY OR TOWN VIENNA COUNTY DORCHESTER STATE MARYLAND			
24. FUNERAL DIRECTOR NAME ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 01 1987 Julia S. Lander						

TO S-T30 25152

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be given to the funeral director. Then please remove carbon papers. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 should be left in the envelope within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												2643	
												REG. NO.	
1 - STATE REGISTRAR			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
DIPOSEE'S NAME (LAST, MIDDLE, FIRST)			RUTH Catherine MORAS			9 16 87			0315				
3. SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) 61 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH DOR MD.						
10 CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) worked in seafood packing			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Toddville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21672				
14 FATHER'S NAME FIRST MIDDLE LAST Levin James Todd		15. MOTHER'S MAIDEN NAME Mary			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-20-4096			17. INFORMANT Tim L. Morris		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure.</u>												ADDRESS 325 Willis St. Cambridge Md.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> .												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
{ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Lymphoma</u>													
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) —								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —								
22a. I certify that (I) (this hospital) attended the deceased from <u>8.30.1987</u> to <u>9.16.1987</u> , that (we) last saw the deceased alive on <u>8.30.1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <u>A. C. Wilke</u>		22c. DEGREE MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9.16.87								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. C. Wilke</u>		22e. ADDRESS 400 Maryland Ave			22f. ADDRESS OGE 21613								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/18/87		23c. NAME OF CEMETERY OR CREMATORIAL DOR MEM PARK			23d. LOCATION CITY OR TOWN CAMBRIDGE COUNTY DOR STATE MD.						
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR SEP 21 1987			25b. REGISTRAR'S SIGNATURE J					

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COLTON ELLIS



X  
24 hours after death. Page 4 may be resuscitated by the hospital attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resuscitated by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, return to the funeral director, page 3 should be detached for use as the burial-form permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is checked on Item 18, then any injury, or other traumatic event, which led to death, must be reported on this certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 2643
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
MADELINE		Aaron	PARKER	9-4-87				5:15 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	White	01	22	04	83	YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.			
Long Island	US									
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House N.H.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
Maryland	Dorchester	Cambridge					520 Glenburn Ave	21613		
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Susie			LAST				
Dolby		Aaron				Simmons				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. No 220-32-0622			17. INFORMANT Alva P. Booze			ADDRESS 1930 Winchester St. Petersburg, Fl. R			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ATHEROSCLEROSIS } DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) OBSTRUCTIVE PULMONARY DISEASE										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AS WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-27, 1986, to 9-4, 1987, that (I) (we) last saw the deceased alive on 9-4, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.										
22b. SIGNATURE Michael A. Moskiewicz	DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> MEDICAL PHYSICIAN			22c. DATE SIGNED 9-4-87 26/3			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Moskiewicz MD	22e. ADDRESS 503 BYRN ST. CAMBRIDGE MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/6/87	23c. NAME OF CEMETERY OR CREMATORIAL Dor Memorial Park			23d. LOCATION CITY OR TOWN Cambridge, Dor. Md.			23e. COUNTY STATE		
24. FUNERAL DIRECTOR Thomas J. Devine Crem. M.				25a. DATE REC'D. BY REGISTRAR SEP 10 1987			25b. REGISTRAR'S SIGNATURE Julia Sanderson-Lundeen			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon paper. It should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
REG. NO. 81 2644																
1 - STATE REGISTRAR			FIRST Walter			MIDDLE ALLEN			LAST Parker			20. DATE OF DEATH 9 15 87	MONTH	DAY	YEAR	2b HOUR 649 AM
3. SEX male		4 RACE white		5 DATE OF BIRTH MONTH April 4, 1914 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 73			IF UNDER 1 YEAR		IF UNDER 2d HRS				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dor.								
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman, seafood dealer			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md.		13b. COUNTY Church Creek		13c. CITY OR TOWN DOR.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21622						
14. FATHER'S NAME FIRST Walter		MIDDLE B.		LAST Parker			15. MOTHER'S MAIDEN NAME FIRST Cleta			MIDDLE			LAST Keene			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-07-9873			17. INFORMANT Frances B. Parker			ADDRESS Box 17								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA TO LIVER												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) CARCINOMA OF COLON												months				
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/10 1987 to 9/15 1987, that (I) (we) last saw the deceased alive on 9/14 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) view the body after death.																
22b. SIGNATURE DAVID B. STOCKELE MD												22c. DATE SIGNED 9/15/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOCKELE M.D.												22e. ADDRESS 200 MARYLAND AVE CAMBRIDGE, MD 21613				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/18/87		23c. NAME OF CEMETERY OR CREMATORIAL TRINITY CHURCHYARD			23d. LOCATION CITY OR TOWN CHURCH CREEK, DOR. MD.			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR SEP 21 1987			25b. REGISTRAR'S SIGNATURE								

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FOR  
ST. B.  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 6

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMERLY RETAINED PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
James			Lio	Parks Sr.		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	26	87	1935 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD			
Male	White	8 10 06	81							9 26 1987	1935 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland		U.S.A.			<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Dorchester County
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Dorchester General Hospital			Ret. Self Employed			Auto Supply					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Dorchester		E-New Market		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 1 Box 167-1		21631			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
James		W.	Parks	Geneva			Parks						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		219-32-1031		James L. Parks Jr.		Bel Air Md. 21014							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>multiple injuries with rupture of aort</i> DUE TO, OR AS A CONSEQUENCE OF  (b) <i>hit by car</i> DUE TO, OR AS A CONSEQUENCE OF  (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												30 min.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 P.M. 9 - 26 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		<i>hit by car</i>							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Peter V. Rieckert</i>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		Peter V. Rieckert		ADDRESS E-New Market, Md. 21631									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		Sep 30 1987		Moreland Memorial		Baltimore		Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leonard J. Ruck, Inc.		Baltimore, Maryland		SEP 30 1987		<i>Julia Davidson-Landess</i>							
DHMH - 17 (VR A15 ME (5)) 15M 2/80													

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busi. in. private current balance with bank art. 2  
and foreign exchange cash, about 5 months.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon stamp. Pages 2 &amp; 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or help 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following forms must be completed and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 26442						
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			3. FIRST MIDDLE LAST			4. DATE OF DEATH MONTH DAY YEAR			5. HOUR 4:15 AM						
Emerson H. Pinkett						March 13 1915			SEPT. 23, 1987									
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vienna, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.			10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Processor		12b. KIND OF BUSINESS OR INDUSTRY Canning	
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Vienna			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RFD1, Box 113		14. FATHER'S NAME FIRST Alexander MIDDLE Pinkett LAST			15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Murray LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Juanita Johnson, Rt.1, Box 42,			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>General debility</u>												20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			22c. DATE SIGNED 9.23.87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carlos F Barroso MD		22e. ADDRESS 317 S. main St, Hurlock Md. 21643								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/26/87		23c. NAME OF CEMETERY OR CREMATORIAL Vienna Cemetery			23d. LOCATION CITY OR TOWN Vienna, Dorchester, MD											
24. FUNERAL DIRECTOR Frampton-Hawkins Funeral Home P.O. Box 43, Federalsburg, Md. 21632		25a. DATE REC'D. BY REGISTRAR SEP 28 1987			25b. REGISTRAR'S SIGNATURE June Dawson Pendleton													

062538-100-585

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from page 3 and attach it to the burial/transit permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the death certificate should be filed at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 2644
1 - STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
CEASED NAME (TYPE OR PRINT) <i>Reita</i>		MIDDLE <i>SPEEDEN</i>	LAST <i>SPEEDEN</i>	SEPTEMBER 14, 1987 4 a.m.	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUC.</b>	5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>10</b> YEAR <b>1896</b>	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b>		
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>DORCHESTER</b>	13c. CITY OR TOWN <b>HUDSON</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>SAME AS # 17 21613</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>
14. FATHER'S NAME FIRST <b>WINFIELD</b> MIDDLE <b>PRICE</b> LAST <b>SPEEDEN</b>	15. MOTHER'S MAIDEN NAME <b>GERTRUDIE MARSHALL</b>				
16a. WAS CEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-82-8364</b>	17. INFORMANT (SON) <b>CAMBRIDGE, MD. 21613</b> ADDRESS DONALD SPEEDEN, RT. 3, BOX 145	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Possible CVA</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)  DUE TO, OR AS A CONSEQUENCE OF (c)  DUE TO, OR AS A CONSEQUENCE OF <i>Generalized arteriosclerosis</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Dysautic B. Syndrome, Dehydration</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. Tanman</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>17 Franklin St. Cambridge, MD</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tanman</i>	22e. ADDRESS 17 Franklin St. Cambridge, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>9-16-1987</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>SPEEDEN-SEWARD CEM</b>	23d. LOCATION CITY OR TOWN <b>DORCHESTER, MD.</b>		
24. FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME</b>	ADDRESS <b>308 HIGH ST.</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1987</b>	25b. REGISTRAR'S SIGNATURE <i>BP</i>		
DHMH - 16 60M 7/B4 (VRA 15, 4)					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE / CERTIFICATE OF DEATH												REG. NO. 26444		
1. DECEASED NAME (TYPE OR PRINT)				FIRST ADA	MIDDLE STANLEY	LAST	2a. DATE OF DEATH	MONTH 9	DAY 24	YEAR 87	2b. HOUR 11 <sup>28</sup> M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH OCT 18 DAY 1892 YEAR 1892			6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD							
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hosp: Tal		12a. USUAL OCCUPATION Retired			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RT II 459 Cambridge, Md.				
14. FATHER'S NAME Caleb		FIRST	MIDDLE	LAST Molock	15. MOTHER'S MAIDEN NAME Eliza			16. ADDRESS			LAST 1/26/13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 217-36-1092		17. INFORMANT Kathleen Temple			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several days.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 19 MONTH DAY 19 P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. DATE SIGNED									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Sept 29 <sup>th</sup>		23c. NAME OF CEMETERY OR CREMATORIAL Christ Cem.			23d. LOCATION CITY OR TOWN Aireys		COUNTY Dorchester			STATE Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS 510 Washington St.			DATE REC'D. BY REGISTRAR 1 OCT 1987			25b. REGISTERED AT			25c. DATE			
Stewart Funeral Home		Cambridge, Md.						Julia Brandon						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

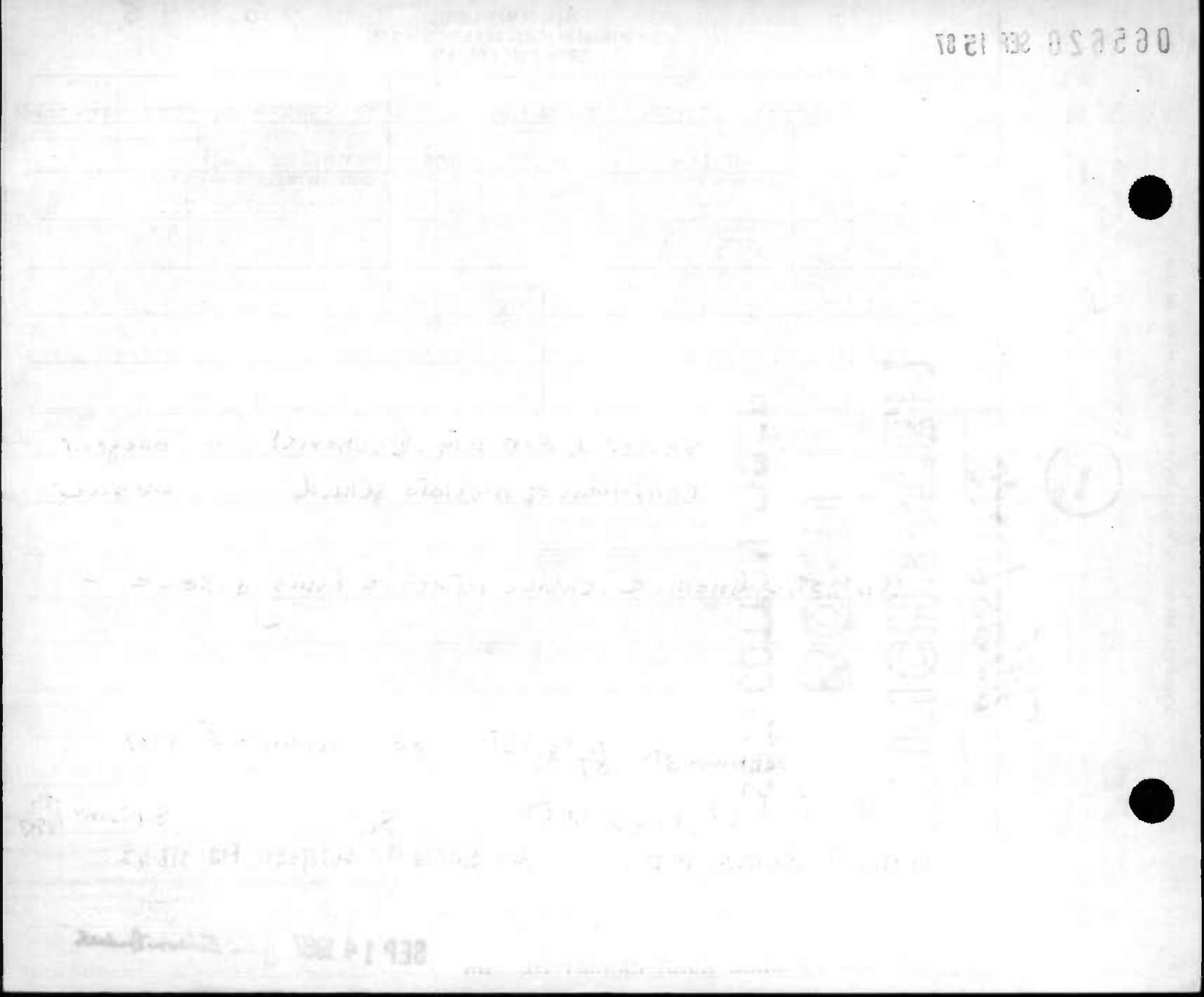
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial/transit permit. Then please attach carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 26445			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Theodore Stubb Tompkins						September 5, 1987						10:30 PM	
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White	Oct 31, 1896			90			YRS.	MONTHS	DAYS	HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Pennsylvania		US	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester Co.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
East New Mkt		Rt 1 Box 167 A-1						Waterman					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Dorchester	E. New Mkt			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt 1 Box 167 A-1 21631				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
William H. Tompkins					Elizabeth					Hardy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes <input checked="" type="checkbox"/>		WW I		164-12-9999		Margaret M. Tompkins			Item # 13				one year
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General debility. (Cachexia)</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of prostate gland</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>One year</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Aplastic Anemia, chronic restrictive lung disease -</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 12</u> , 19 <u>86</u> , to <u>September 5<sup>th</sup></u> , 19 <u>1987</u> , that (II) (we) last saw the deceased alive on <u>September 5<sup>th</sup></u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Carl S. Barrios MD.</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>September 7<sup>th</sup> 1987</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carlos S. Barrios MD.</u>		22e. ADDRESS			300 Collins Av., Hurlock Md. 21643.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
Burial		9/9/87		Md. Veterans Cem			Hurlock		Dor	Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
THOMAS FUNERAL HOME CAMBRIDGE, MD.					SEP 14 1987			Julia Brandon-Randall					

BP \_\_\_\_\_

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										26416		
										REG. NO.		
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR	
		Richard Gilbert Tyler						<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	
		24 87	SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	<input type="checkbox"/>	9	15	87
		male	White	08 04 61	26				<input type="checkbox"/>	19		
		7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		2c. DATE PRONOUNCED DEAD			
		Cambridge, Md.		USA			<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	9	15	87
							<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	19		
		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
		Rhodesdale		Rt. 1, Box 34-1			Fork Lift Operator Concrete			21659		
		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
		Md.		Dor.		Rhodesdale		<input type="checkbox"/>		Rt. 1 Box 34-1		
		14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	
		Gilbert Tyler					Belva Lou Elzey					
		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
		No		218-74-2451			Lisa P. Tyler, Rt. 1, Box 34-1. Md.		Rhodesdale,			
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
		ACTUAL SIGNATURE		TITLE (SPECIFY) <i>Peter W. Rieckert</i> M.D. Dep.						MEDICAL EXAMINER		
		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						DATE SIGNED		
		Peter W. Rieckert, M. D.		East New Market, Md. 21631						9-16-87		
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
		Burial		Sept. 18, 1987		E. New Market Cem.			COUNTY			
		24 FUNERAL DIRECTOR NAME		ADDRESS		Federalburg, Md.			STATE			
		Frampton-Hawkins F.H.		216 N. Main St.		SEP 21 1987			Julia Sanderson-Lundres			
		25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

26447

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
<i>Reginald Henry Wingate</i>						9	2	87	443 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
<i>Male</i>		<i>White</i>		MONTH DAY YEAR <i>Oct 14, 1910</i>		MONTH DAY <i>76 YRS</i>		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
<i>Texas</i>		<i>US</i>				<i>Dorchester</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
<i>Cambridge</i>		<i>Dorchester General Hospital</i>		<i>Power Co Worker</i>						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
<i>Maryland</i>		<i>Dorchester</i>	<i>Cambridge</i>			<i>Rt 1 Box 155</i>		<i>21613</i>		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
		<i>Walter</i>	<i>E.</i>	<i>Wingate</i>	<i>Laura</i>				<i>Murphy</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
<i>NO</i>		<i>214-07-7407</i>		<i>Mabel R. Wingate Item # 13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), 1b <sub>2</sub> , and 1c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>cardiac arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>recent myocardial infarction</i>										
{ DUE TO, OR AS A CONSEQUENCE OF (c) }										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>diabetes, hypertension</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 84</i> to <i>Aug 19 87</i> , that (I) (we) last saw the deceased alive on <i>Aug 19 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I)(we)(did)(did not) view the body after death.										
22b. SIGNATURE <i>Robert Jardine</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED <i>9-2-87</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>9/4/87</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Green Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Cambridge</i>		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME CAMBRIDGE, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 8 1987</i> 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Landree</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of a physician or licensed practical nurse.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked *deceased*, show any injury, or other traumatic event, the medical examiner will be notified.

002022-932-e1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26448
1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTIMATED	2d MONTH YEAR	DAY	2b HOUR			
1887			SHERWOOD	YOUNG		9-8-87	19		M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	2d. MONTH YEAR	DAY	2e. HOUR			
Male	Black	June 5 1915 72	72 yrs.			9-8-87	19		12:35P			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.					Dorchester County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Dorchester County Hospital			Retired							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Md.	Dorchester	Cambridge			Fairmount Ave/21613							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Thomas				Kep Kiner	Elizabeth Young							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS						
(YES, NO, OR UNKNOWN)		220-10-6229		Elsie Hughes		8019 Hill St, Camb.						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/21 IMMEDIATE CAUSE (a) Neck and thoracic spine injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20d. AUTOPSY?							
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY APPROX. MONTH DAY YEAR 11:20am 9-8-87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
					passenger of an auto/truck impact							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.			21f. LOCATION STREET Rt. 235 & Key Wallace Rd. nr. Dorchester Co., Md.		CITY OR TOWN church creek, Md.		COUNTY Dorchester Co., Md.		STATE Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Margarita Korell		TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER		DATE SIGNED 9-10-87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/12/87			23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		23d. LOCATION CITY OR TOWN Cambridge, Md.		COUNTY Dorchester Co., Md.		STATE Md.	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home Camb. Md.		ADDRESS 510 Washington St.			25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE Julia Sanderson Pendleton					

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